South East **LHIN**

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2010-2011 Annual Report

South East Local Health Integration Network

Ontario
Local Health Integration Network

Board of Directors

Georgina Thompson (Chair)
Appointed: 9 June 2008
Term Expires: 8 June 2011

Jyoti Kotecha
First Appointed: 24 Mar 2010
Term Expires: 24 Feb 2013

John Ferguson
First Appointed: 19 June 2008
Term Expires: 19 June 2011

Andreas von Cramon
First Appointed: 28 April 2010
Term Expires: 28 March 2013

Leslie Benecki
First Appointed: 8 October 2008
Term Expires: 7 October 2011

Arthur Ronald
First Appointed: 10 August 2010
Term Expires: 10 July 2013

Wynn Turner
Appointed: 1 November 2009
Term Expires: 31 October 2012

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Term Expires: 14 September 2013

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Term Expires: 17 June 2010

Thomas Rankin
Appointed: 17 June 2007
Term Expires: 16 June 2010

John Groves
Appointed: 8 April 2009
Term Expires: 7 April 2010

Senior Executive

Paul Huras
Chief Executive Officer

Sherry Kennedy
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Messages from the Board Chair & Chief Executive Officer

On behalf of the Board of Directors of the South East Local Health Integration Network, I am pleased to provide our 2010-2011 Annual Report.

At the same time, however, I must admit to a certain degree of mixed feelings, since this year's Annual Report is the last one to be submitted during my term as Board Chair of the SE LHIN.

Over the past six years in which it has been my privilege to fulfill that role, I have always been proud of the accomplishments we have achieved and grateful for the support and encouragement from my fellow Board members, our CEO, and the dedicated team of LHIN staff specialists who work so hard on behalf of residents across our region.

I also want to thank the executive and staff of the Health Service Provider partners across our region who demonstrate, consistently and unfailingly, their commitment to providing the highest-quality of health care for the nearly 500,000 people who live and work in southeastern Ontario.

So, while I look back with pride on the distance we have travelled together – and while I can easily see a horizon upon which access to quality care will continue to grow and improve – I confess I will miss the day-to-day issues my colleagues and successors will navigate as they achieve even greater success and refinement of the patient-centred health-care system we are striving to build.

Georgina Thompson, Board Chair

I join our Board Chair in expressing my pride as we submit our 2010-2011 Annual Report for the South East LHIN.

This has been a remarkable year. One in which we have moved so much closer to a fully-integrated, and ultimately highly-beneficial, regional system of health care – particularly with our Regional Clinical Services Roadmap initiative that has evolved from a noble idea arising out of our IHSP2, into a tangible, workable strategy that is poised for final approvals and eventual implementation.

Along the way, we have relished our role in marshaling significant change and improvement in the delivery of health care services to all residents across the south east. We could not have accomplished this without the dedication and commitment of our Health Services Provider partners. We could not have moved programs forward without the professionalism and hard work of our staff.

And we certainly could not have captured the imagination and support of our community without the talents, the energies and the profoundly intuitive instincts of our Board Chair. She has worked tirelessly to establish a governance model that affords us the momentum we need to continue providing all residents across this region with the highest-possible quality of care.

And for that, we are deeply indebted to her.

Paul Huras, CEO

Overview

FACTS & FIGURES

Population **442,800** (2006) *projected* **489,600** (2010)

Funding **$1,017,913,350** Allocated to health service providers in 2010/11

Providers

7	Hospitals operating 11 sites
1	Community Care Access Centre (South East)
37	Long-term care homes

Community Agencies

34	Community support service agencies
3	Acquired brain injury program agencies
3	Assisted living / supportive housing agencies
8	Addictions program agencies
5	Community Health Centres
16	Mental health program agencies

Funding by Sector (2010/11)

Operation of Hospitals	$676,287,800
Municipal Tax Grants–hospitals	$190,725
Long-Term Care Homes	$157,270,059
Community Care Access Centre	$96,933,755
Community Support Services	$24,032,306
Acquired Brain Injury	$3,436,399
Assisted Living Supportive Housing	$2,003,991
Community Health Centres	$18,371,488
Community Mental Health	$33,083,729
Addictions Program	$6,303,138
Total Funding Allocated	**$1,017,913,350**

Funding by Hospital (2010/11)

Brockville General Hospital	$51,037,304
Hotel Dieu Hospital	$53,296,417
Kingston General Hospital	$288,624,120
Lennox & Addington County General	$20,331,700
Perth & Smiths Falls District Hospital	$35,727,500
Providence Care	$88,741,459
Quinte Healthcare Corp	$138,529,300
Total Funding (Hospitals)	**$676,287,800**

Community Overview

At 19,473 square kilometers, the South East LHIN is the fourth largest local health integration network by geographic area. We serve approximately 3.8% of Ontarians who live, in almost equal proportion, along a ribbon of more urban areas following Highway 401, or in small rural communities located across the remainder of the area.

The SE LHIN geographic area includes the communities bounded by the towns of Brighton and Cardinal from east to west, and from Prince Edward County to just north of Lake St Peter from north to south (see Figure 2). LHIN geographic areas were determined based on where residents primarily received their care. Approximately 98% of all South East LHIN residents obtain care from local health service providers.

Percentage funding distribution by sector 2010/2011

Accountability and Responsible Health System Management

LHINs were developed with accountability as a core value. The *Local Health System Integration Act, 2006 (LHSIA)* specifies the powers of the LHIN Board to make decisions regarding the local health system, within the provisions of the *Act* and under the stewardship of the Ministry of Health and Long-Term Care (MOHLTC). The LHIN is required to engage in consultations with its communities as part of its strategic-planning and priority-setting cycles. Decisions of the LHIN must be made in full consideration of the public interest.

Every three years, LHINs develop their Integrated Health Services Plan (IHSP) – which defines our strategic objectives for the local health system. The IHSP provides a framework for the LHIN and our health service providers to ensure that time, effort and resources are appropriately aligned.

Each LHIN has a Performance Agreement between itself and the Minister of Health and Long-Term Care. That agreement specifies the obligations of both parties, as well as identifies areas where the ministry wants to see improvement. Performance indicators, along with multi-year targets, are set out in this agreement, and the results are reported publicly, through this report and other channels.

As a Crown Agency, the LHIN is fully responsible for following Directives from the Province of Ontario regarding allocation of funding, operational spending, tendering for third-party services, hiring, and other policies that are directed towards Ontario's agencies, boards and commissions.

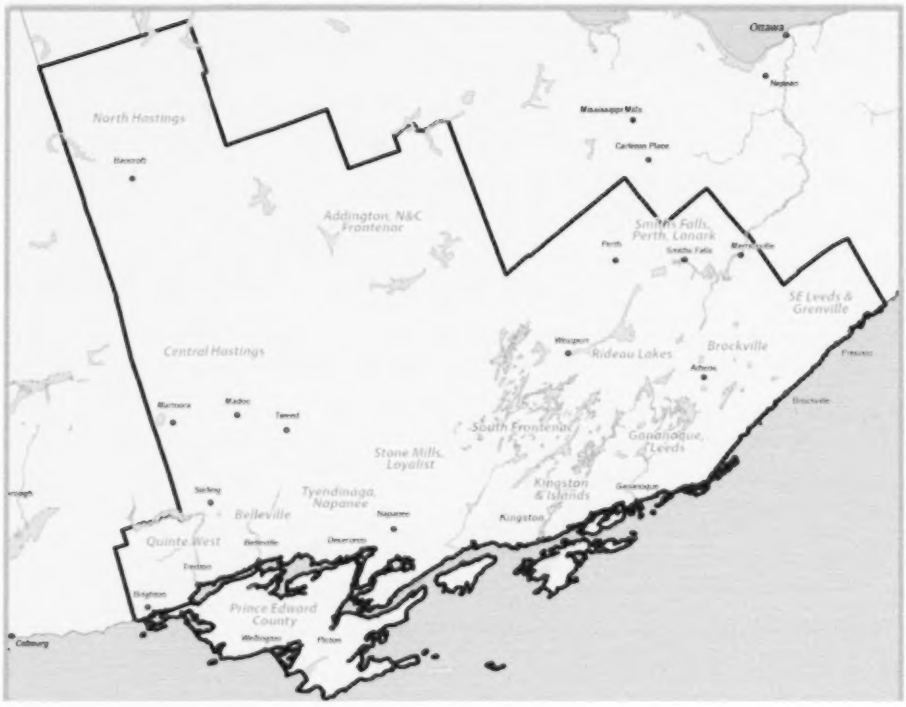
The Chief Executive Officer of each LHIN has quarterly meetings with senior ministry officials to brief them on the impact of the LHIN's activities, highlighting successes as well as opportunities for improvement.

The LHIN Board of Directors has ultimate accountability to the Minister of Health and Long-Term Care. All major decisions taken by the LHIN are directed by our Board. Our CEO provides monthly updates on operational activities, reports on performance indicator results, as well as updates on our progress towards achieving our IHSP priorities.

Within this accountability framework, the South East LHIN Board has set in place four corporate strategic goals:

- *To build a true system of integrated health care that optimizes the use of resources*
- *To build understanding of the role of the SE LHIN in developing and managing a regional system of integrated care*
- *To build a functional integrated e-health system that supports better health care services and healthier citizens*
- *To demonstrate leadership as a knowledge–based organization that is credible, professional, proactive and responsive.*

LHIN Board members, executive, and staff are fully briefed on our accountability relationships and are required to incorporate the deliverables contained in them into their relationships with our HSPs, as well as into their work activities.



Map of the South East Local Health Integration Network Area

As important and necessary as these formal accountabilities are, they do not speak directly to our most important accountability – the residents who live within our geographic area.

The Board and staff of the South East LHIN are also residents of this community. We share the vision of an accessible and sustainable health-care system expressed by residents.

Being accountable is more than reporting the right numbers. In the South East LHIN, it means making decisions that will have a positive impact on the quality and sustainability of the health system. It means making things work better, and doing what makes sense.

Meeting provincial standards

The South East LHIN has worked diligently with its health service providers to ensure that provincial standards of care are met by addressing local health-care needs. We have been innovative so that our engagement with our communities was significant and meaningful, allowing us to develop an approach that reflected community input. We have looked beyond Ontario's borders to find models, programs and processes that have been proven to provide services more efficiently and effectively, or which help people avoid typical — but preventable — reasons for accessing the health care system. Our objective is to enhance and evolve the local health-care system to ensure it meets, and continues to meet, the needs of our residents.

Major accountability projects

As part of our mandate, the South East LHIN has undertaken a number of projects that support our accountability relationships, priorities for change at a health-systems level, or improve our overall understanding of the local health-care system. In 2010/11, the LHIN engaged in several projects of this type.

South East Community Care Access Centre (CCAC) Performance Assurance Review (PAR)

One critically-important aspect of the SE LHIN's commitment to ensuring that residents of this region have access to the support services they may require is our obligation to monitor the performance and efficiency of the Health Service Providers who are charged with the responsibility of delivering that support. In response to a number of concerns regarding the South East CCAC's ability to meet their clients' needs consistently and effectively, the SE LHIN enlisted the help of an independent management consulting group to conduct an objective review of that organization's strategic and operational performance.
The results of that performance review led to changes in CCAC leadership and the implementing of an overall, onging, improvement plan that has yielded positive early results.

Community Services Back Office Project

As part of our accountability agreements with community providers, each are participating in an exercise to determine what core administrative services could be combined and shared through a common 'back office'. The intent of the project is to determine how much could be saved throughout the system by, for example, having a single payroll system, or a common bookkeeping office. Phase I of this project, which involved an assessment of what back office services could be shared, was completed in 2009/10.

Phase II, the development of options for a back office approach, culminated in the Fall of 2010 with the SE LHIN Board approving the implementation of initiatives such as a common purchasing plan, models for transactional accounting services, and a shared benefits plan. Phase III, the implementation of these initiatives, began this past fiscal year and will continue into 2011-2012.

Shared Support Services of Southeastern Ontario (3SO)

Similar in nature to the Back Office Project, 3SO is a collaboration of the South East LHIN hospitals to create a shared back office for purchasing and procurement services. Employing staff who are expert in procurement, 3SO leverages the purchasing power of all the hospitals, allowing hospital management to focus on their core business of providing excellent patient care.

Service Accountability Agreements (SAAs)

With the enactment of the *Local Health System Integration Act, (LHSIA)* in 2006, the LHINs assumed full responsibility for planning, funding and integrating health services in their geographic areas.

In fulfilling that responsibility, they began the negotiation of service accountability agreements

(SAAs) between themselves and the health service providers (HSPs) they funded. In accordance with the timetable set out in *LHSIA*, Hospital SAAs (H-SAAs) were negotiated for 2008-10. Multi-Sector SAAs (M-SAAs) were negotiated with community support services agencies, community care access centres, community health centres and community mental health and addictions agencies for 2009-11.

In 2010, the SE LHIN successfully negotiated Long-Term Care Home (LTCH) Service Accountability Agreements (L-SAAs) with 37 Long-term Care Homes in the south east.

The L-SAAs represent important changes for the long-term care sector and for the LHINs. They focus on accountability and performance and are an integral component to the ongoing effort to improve health system performance and provide high-quality, resident-centered care. They also emphasize the important collaborative role the sector plays in enhancing the stability and accountability of our health-care system, and support the alignment of health services across the various sectors.

The second Integrated Health Services Plan (IHSP2) for the South East LHIN was completed in 2009. It builds upon the progress made to improve local health care since the first IHSP was approved in October, 2006.

In preparing this plan, we conducted extensive evidence-based research on the health of our residents to find out what health-care services they used. We also talked to Ontarians who live in the communities we serve to gain their views about the local health-care system. We asked what was good about health care locally and what could be improved. We also asked what the future local health-care system should look like. Finally, we consulted with our providers to gain their perspective of the local health system's strengths, opportunities for improvement, and generally how well they saw the system meeting people's needs.

The outcome of this research was IHSP2, and the Ten Priorities that will direct the LHIN's activities from 2010/11 through 2012/13. A full copy of IHSP2 is available at www.SouthEastLHIN.on.ca

We are very proud of the accomplishments our health service providers have made, and that we have achieved collectively over the past four years. The results speak to the dedication and commitment of every health-care provider in this LHIN, as well as to the administrative, operations, and support people behind them.

One of the concerns raised in health care is that there is so much change, people just can't keep up. We think our results tell a different story. Change for the sake of change is not sustainable. However, change that fits with a vision of success *is* sustainable. Change linked to a clearly-articulated goal, with a way to measure progress towards that goal, can energize people.

There is nothing stagnant about health-care. Medical discoveries have not slowed down over the last 20 years. Surgical residents today are not learning the same techniques and approaches that their teachers learned. Everything in health care is changing all the time. The LHIN's role is to ensure that change is focused on what is important to the health-care needs of our residents now and into the future.

IHSP2 told us that the system was, largely speaking, doing what it was supposed to do. Our job in IHSP2 was not to create a new local health-care system, but to 'renovate' the existing one.

In all, there are ten priorities set out in IHSP2 to assist the South East LHIN in creating an accessible, sustainable system for care. In turn, these priorities will also position care so that it is provided in the right place at the right time. These system improvements will enable the acute-care system to be better able to focus on its role.

Our report on IHSP2 is listed by each of the ten priorities identified in it, and a summary of key activities supporting those priorities.

1 Developing a System of Primary Health Care

Access to Primary Care has been identified as an immediate priority in IHSP2 since it deals with most health problems encountered by most people most of the time and is often the main entry point into the health-care system. As such, Primary Care must be accessible whenever health needs arise; it must focus on individuals over the long term; and it must offer comprehensive care for all health problems.

Activities supporting this priority

Health Care Connect: Healthcare connect is a provincial service, conceived and developed in the South East LHIN, that provides a means for Ontarians to obtain a primary health care practitioner without having to canvass all local physicians.

In 2007, approximately 80% of Ontarians living in the South East LHIN did not have a primary health care provider. By December 31st, 2010, approximately 98% of those who wanted a primary health care provider had one – the highest such rate in the province.

Primary Health Care Council: The South East LHIN established our Primary Health Care Council two years ago. The Council is charged with the responsibility of advising the LHIN on how best to build a system of primary care. It is comprised of primary care providers from across the LHIN. In January, 2011 the Council hosted the third Annual Primary Health Care Forum, "Strengthening Primary Care Across the Region and Sharing Innovations in Health Care Delivery" providing an opportunity for researchers, policy decision-makers and members of the primary health care community to meet and discuss areas of mutual interest.

Community Health Centre Satellites: As part of the 2005 Government of Ontario- announced plan to expand the number of community-based primary health Community Health Centres (CHCs) across the province, a series of community consultations was held on where to locate them. In 2010/11, the Cities of Belleville and Quinte West opened their sites in Trenton and downtown Belleville, giving more access to frontline healthcare to more residents.

Primary Health Care Support: In the face of a sudden critical shortage of primary care physicians in Smiths Falls early in the New Year – precipitated by the untimely passing of a family practitioner shortly after two local doctors had already retired – the SE LHIN provided support funding that enabled increased visits by a mobile health clinic van from nearby Brockville, and allowed expanded capacity for 800 additional patients to receive care from the Merrickville District Community Health Centre.

2 Enhancing a Culture of Patient-Centred Care

The need for patient-centred care is commonly expressed by the public as an expectation of our health-care system. Patient-centred or patient-directed care includes good "customer" service, access and responsiveness. It also includes assistance in navigating and coordinating the many components of care or treatment a patient may require to maintain or improve health. Patient-centred care is about quality service and quality care, where the needs of the patient and the population drive the utilization and deployment of resources. Within the South East LHIN, a culture of patient-centred care must be fostered to ensure our system is integrated and appropriately responds to the needs of the individual and the population.

Activities supporting this priority

Wait List Management: The South East LHIN has maintained the requirement of hospitals providing services funded under Ontario's Wait Time Strategy to audit their wait lists to ensure that anyone waiting longer than 180 days for hip and knee surgeries was reassessed.

Directed funding: The LHIN re-allocated funding within the fiscal year to ensure hospitals that could perform more surgeries had the resources to provide them.

Excellent Care for All Act (ECFAA): Since this Act came into effect in July, 2010, the South East LHIN has been active in educating and promoting to our HSPs the spirit and requirements of the legislation; and assisting our Hospitals with the review and completion of their Quality Improvement Plans (QIPs).

Senior-Friendly Hospitals: The recently-introduced *"Senior-Friendly Hospital"* philosophy has found expression in the SE LHIN's Clinical Services Roadmap initiative where elements have been incorporated into the Clinical Work Plans developed for the *Emergency Department Wait Times* and *Restorative Care* areas of clinical opportunity.

Integrating Information Systems: Two projects were completed in 2009/10 that improved the seamless transition of care between providers by leveraging information technology. Information technology systems between two Family Health Teams and their nearest hospitals have provided family doctors with real-time access to hospital charts, clinical notes, diagnostic reports and specialist consultations. Where implemented (Kingston and Belleville) this has resulted in a significant reduction of the administrative burden for family physicians (57% reduction in hardcopy reporting, 24 to 72 hour reduction in report turnaround times), who are now acting on current information instead of chasing after dated reports or having to repeat tests unnecessarily.

Standardized Assessment: Community Support Service Agencies completed training to adopt the interRAI Community Health Assessment tool (interRAI-CHA) throughout the south east. The use of standardized community assessments will enable consistent evaluation and determination of required services; an improved knowledge and understanding of the clients being served in the community; and the ability to quantify the impact of services on clients' lives. It also supports a shared understanding of levels of care and client need among health service providers, which improves clinical decision-making. Projects like this are a necessary step towards the development of an electronic health record.

Improved coordination of care: Work done as part of our *Aging at Home* strategy has improved the dialogue and cooperation between hospital discharge planners, CCAC case coordinators, and community service support case coordinators within the LHIN. Over the last three years, an increase of 45% in referrals to CSS agencies has been noted, providing more people with the support they need to stay at home.

3 Improving Mental Health and Addictions Services Capacity

In keeping with the planned development of the 10-year strategy on Mental Health and Addictions for the province, the South East LHIN will focus its efforts on integrating mental health and addictions services across the levels of care and with the main health-care system. Our efforts will focus on early identification and intervention in a seamless system of comprehensive, effective, efficient, proactive and population-based services and supports by revaluating current resources.

Activities supporting this priority

Transitioning long-stay mental health patients to community living: During this past year, the SE LHIN, working with hospital and community support providers, was instrumental in facilitating the closure of the transitional bed units at the Brockville site of the Royal Ottawa Health Care Group (ROHCG). All SE LHIN clients were successfully placed. Providence Care continues to work with community agencies in transitioning those identified as long-stay mental health patients into the community.

Acute Mental Health: With the successful completion of a negotiated funding agreement between Kingston General Hospital (KGH) and Hotel Dieu Hospital, KGH has designed a patient-care model that reflects current clinical best practices for the new acute care setting transitioning from Hotel Dieu Hospital. Similarly, Brockville General Hospital is designing a care model as part of their preparations to accept the transfer of acute care services for mental health from ROHCG. With much of the groundwork having been completed during the latter part of this year, this transition is expected to be finalized in the near future.

Behavioural Support Services: A significant investment of time and resources has been channeled into the development of a BSS model for the SE LHIN – including considerable engagement of various cross-sector representatives and the development of critical pathways to manage patients presenting in different clinical settings such as Emergency Departments and Long-Term Care Homes. This model has resulted in better-quality care and support in the community for those elderly patients (and their families) who are coping with behavioural issues.

Diversion from Emergency Rooms of MH&A patients: Having gained a more thorough understanding of the ways in which MH&A patients tend to present repeatedly to hospital emergency departments, it is well recognized that a relatively few patients can have significant impact on ER volumes. One strategy to decrease these volumes includes formalized case-conferencing consultation between the hospital ED and community support providers, including peer support to identify specific individuals who can be better managed with targeted care outside of the ER setting.

Coordinated Access: During this past year, M&HA providers have been working together to establish common protocols and standardized processes to help manage – on a 24/7 basis –individuals seeking crisis support and referral throughout the SE LHIN region. The goal is to build on work already completed in the Hastings-Prince Edward region through 310-OPEN, a crisis line service. An important component of this work will include a standardized screening tool to identify concurrent disorders.

4 Developing Regional Program Management

Residents of Southeastern Ontario express a need for improved access. What they often mean is enhancing capacity or providing more service. Access can be improved, capacity enhanced and service increased through better system management of our current regional resources. This is the concept of getting more from what is available. Regional program management is about managing health services, which may currently be managed separately in two or more sites across our region, as one program. It includes services that are delivered in multiple sites and are integrated across the region depending on volumes and availability of resources.

Regional program management would allow for a clinical and administrative lead to facilitate the development of a common vision and targets, thus improving accountability for service performance across the region.

Activities supporting this priority

The South East LHIN Regional Clinical Services Roadmap: As the catalyst to achieving a truly regionalized system of integrated health care, the Regional Clinical Services Roadmap has been the mainstay of the SE LHIN's strategic plan throughout this past year.

In collaboration with our seven hospitals and the SE CCAC, the SE LHIN undertook a broad-based planning initiative to address the most pressing issue in health care in Ontario and Canada – ensuring that the local health system provides each and every resident with the right care, at the right time, in the right place.

Conceived and developed on the driving principles of sustainability, access, efficiency and quality, the Clinical Services Roadmap has the ongoing collective support of the South East CCAC and Hospital Executives Forum (SECHEF) as well as the support of the SE LHIN, hospitals, and CCAC Board Chairs. Since the launch of the Roadmap in July, 2010, all Boards have been fully briefed twice on the progress and goals of this initiative. Additionally, in late 2010, the hospital and CCAC Board Chairs each signed a charter of support for the Roadmap.

Through the involvement of our Knowledge Management team – and with the insights provided by their highly-acclaimed report on the *Regional Analysis of SE LHIN Hospital Services* – the SE LHIN thoroughly investigated the current and projected health-care needs of our residents. As part of this analysis, we worked with our partners to identify areas where the investment of time and energy of our front-line doctors and clinicians would provide the greatest gains for our residents. Careful review and consultation identified seven clinical "areas of opportunity" including Cardiovascular, Surgical Services, Mental Health and Addiction Services, Restorative Care, Emergency Department Wait Times, Maternal/High-Risk Newborn Care, and Healthcare Acquired Infections (HAI).

Since the launch of the CSR last July, individual Clinical Work Teams comprised of doctors, nurses, and clinicians – headed by physician and SE LHIN administrative leads – have been working to develop Clinical Work Plans specific to each of these areas of opportunity. Those work plans are now at a draft stage and were the focus of a region-wide Community Engagement process that was launched on March 21st. This process captured input and opinion from residents who were encouraged to participate online where they were asked to complete and submit workbooks for each clinical area.

The results of this broad-based exercise will be analyzed and incorporated into the final workplans as they are put forward for final approval from SECHEF and the hospital/CCAC Boards by the end of 2011. Implementation of these work plans would then take place over the next one to three years.

Community Engagement

The singular focus on Community Engagement within the SE LHIN for 2010/11 was the imperative to engage with as many residents as possible in capturing feedback on our Clinical Services Roadmap process.

In fact, public and community engagement as it relates to CSR began with the official announcement of this initiative in July of 2010. Media coverage surrounding the announcement, and the description of what CSR was designed to achieve, became the first step in informing and educating the public. Subsequent, more formalized, engagement was considered and developed from there.

One of the most important early steps was a series of presentations by the Board Chair and CEO of the SE LHIN to *every* municipal, regional and county Council across this region. These presentations were rolled out beginning in mid-December and continuing through until the end of March, and provided Mayors and Councillors with a courtesy heads-up on the advent and significance of the Clinical Services Roadmap.

In considering how to engage the general population on CSR, we pursued a different direction.

While the community engagement surrounding the SE LHIN's IHSP2 in 2009 relied exclusively on traditional face-to-face in-person meetings, open houses and other events – and while that process was diligently planned and promoted – we wanted to do better.

In our determination to reach a broader cross-section of residents across this region to help guide and validate the Clinical Work Plans being developed for the Roadmap, we recognized we would have to engage residents in a way that was easy, convenient and non-intrusive.

Following careful deliberation, the SE LHIN decided to predicate its CSR engagement on a new web-based approach that would drive residents to a dedicated site where they could learn as much or as little about CSR as they wished – and where they could take advantage of the opportunity to fill out and submit one or more workbooks on specific areas of clinical opportunity that interested them most.

In the wake of a rigorous procurement process conducted through 3SO, and with a strong endorsement referral from colleagues at the North West LHIN who had worked with them on a similar engagement, we enlisted the expertise and experience of an Ottawa-based Social Media and Public Outreach group, *Ascentum*, to help design a strategy and approach that would accomplish our objectives.

Using a suite of tools that included e-mail blasts, earned media coverage, paid advertising and formal requests to Community Service Agencies, Public Libraries, School Boards, Churches and the medical community to help promote and deliver people to the site, we launched a six-week online engagement process on March 21st .

The dedicated website, created solely for our engagement initiative, featured a home page with a welcoming video from the SE LHIN CEO outlining the Clinical Services Roadmap and encouraging visitors to explore further at their leisure.

Individual visitors could then click on any or all of the seven clinical areas of opportunity, where they could view similar introductory videos from each of the Clinical Work Team leads (all but one of whom are physicians) with an invitation to browse that clinical area and complete the workbook.

While this certainly fit the profile for the kind of engagement approach we had envisioned, we also recognized that we should stage, face-to-face events for key groups of residents who might prefer in-person contact as a means of sharing their feedback. Accordingly, and with the availability of the SE CCAC's technology and venues, seven such events were held for Seniors across the region. One other event was later held for francophone residents in the designated FLS centre of Kingston.

Despite several attempts to structure a similar CSR engagement event for members of the Aboriginal, Mohawk Council and Metis groups, efforts by the SE LHIN to do so were met with a more neutral response.

South East LHIN
What kind of health care do you want?
We need to hear your views to help us design a new regional health care system, in which patients are diagnosed, referred, and treated in the most efficient, effective way possible.
Visit us online to learn about the Clinical Services Roadmap and share your views and stories about patient care now and into the future.
Hurry! Take part before May 15, 2011!
www.southeastlhin.on.ca/HealthCareRoadmap
CCAC CCSC
Brockville General Hospital
Perth and Smiths Falls District Hospital
Providence Care
Hotel Dieu Hospital
QHC Quinte Health Care
KGH Kingston General Hospital
Ontario
South East Local Health Integration Network
Reseau local d'intégration des services de santé du Sud-Est

Paid advertising proved effective in engaging the community

5 Improving Access in Emergency Room Care

Emergency rooms are seen as the "canaries in the mine" of the health-care system. That means if something is not right with the local health system, it is often exposed from one's experience in the emergency room. When appropriate access to and flow through an emergency room is timely and successful, the public is confident that the health system is functioning well. A truly integrated health-care system makes the most effective use of the emergency rooms. We have an opportunity to improve access to and from the emergency room. All LHINs view this as an essential priority for change.

6 Reducing the Incidence and Prevalence of Alternate Level of Care

When someone is placed into an acute-care bed who does not need acute care or someone stays in an acute-care bed when they no longer require acute care, the patient and the system are both compromised. The patient may lose strength or acquire an infection and the system loses or misuses valuable capacity. All patients should be appropriately placed in the setting that best fits their care needs.

Note: *Given the ways in which our priorities of "Improving Access in Emergency Room Care" and "Reducing the Incidence and Prevalence of Alternate Level of Care" are inextricably linked, and govern so much of what we do across the South East region, we offer the following synopsis of how these two priorities are addressed within the SE LHIN.*

Understanding the Emergency Room-Alternate Level of Care Relationship

On the surface, the connection between Emergency Department volumes and how patients are discharged from hospital is quite straightforward. Assuming full occupancy, for every new patient to be admitted another patient needs to be discharged. When the SE LHIN started to consider this problem, we became more interested in knowing about the patients who were coming to the ED, why they were being admitted and why they had difficulty going home after their hospital care had ended.

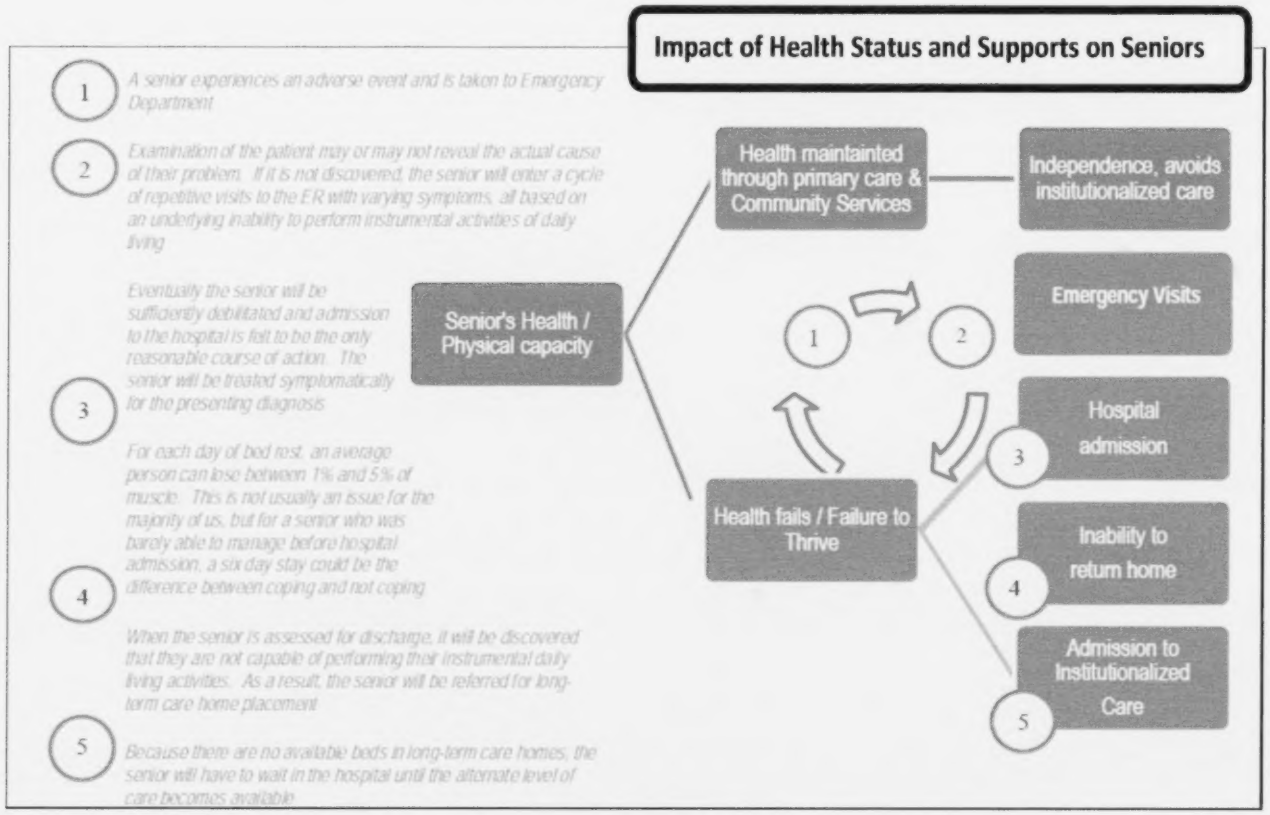
The SE LHIN used known demographics, clinical data, and information provided by front line staff to develop a profile of the type of patient most likely to arrive at the Emergency Department; be admitted to a ward in the hospital (even though their condition was not immediately life threatening); and subsequently very likely to be referred for placement in a long-term care home.

Our research showed that this typical ER/ALC patient would likely be:

- *Over the age of 75*
- *Living alone, or acting as the primary caregiver for a spouse who could not take care of him/herself*
- *Someone who had recently experienced the death of a spouse, loved-one, or primary caregiver*
- *Someone who had been diagnosed as having at least one chronic disease (such as congestive heart failure, diabetes, etc.)*
- *Someone who had experienced a recent change in health status*

Each of these characteristics speaks to a single event or combination of factors that can render a senior unable to cope with their daily living circumstances.

Once that happens, any adverse event – such as slipping and falling or becoming dehydrated – will likely result in a trip to the emergency department.


Impact of Health Status and Supports on Seniors
1
A senior experiences an adverse event and is taken to Emergency Department
2
Examination of the patient may or may not reveal the actual cause of their problem. If it is not discovered, the senior will enter a cycle of repetitive visits to the ER with varying symptoms, all based on an underlying inability to perform instrumental activities of daily living
3
Eventually the senior will be sufficiently debilitated and admission to the hospital is felt to be the only reasonable course of action. The senior will be treated symptomatically for the presenting diagnosis
4
For each day of bed rest, an average person can lose between 1% and 5% of muscle. This is not usually an issue for the majority of us, but for a senior who was barely able to manage before hospital admission, a six day stay could be the difference between coping and not coping
5
When the senior is assessed for discharge, it will be discovered that they are not capable of performing their instrumental daily living activities. As a result, the senior will be referred for long-term care home placement
Because there are no available beds in long-term care homes, the senior will have to wait in the hospital until the alternate level of care becomes available
Senior's Health / Physical capacity
Health maintainted through primary care & Community Services
Independence, avoids institutionalized care
Emergency Visits
Hospital admission
Inability to return home
Admission to Institutionalized Care
Health fails / Failure to Thrive
1
2
3
4
5

The SE LHIN ER/ALC Strategy

Our strategy addresses the circumstances that bring patients to emergency departments, and the chain of events that can occur if there is no concerted effort to return a client home with appropriate support.

Three main areas are addressed by the strategy:

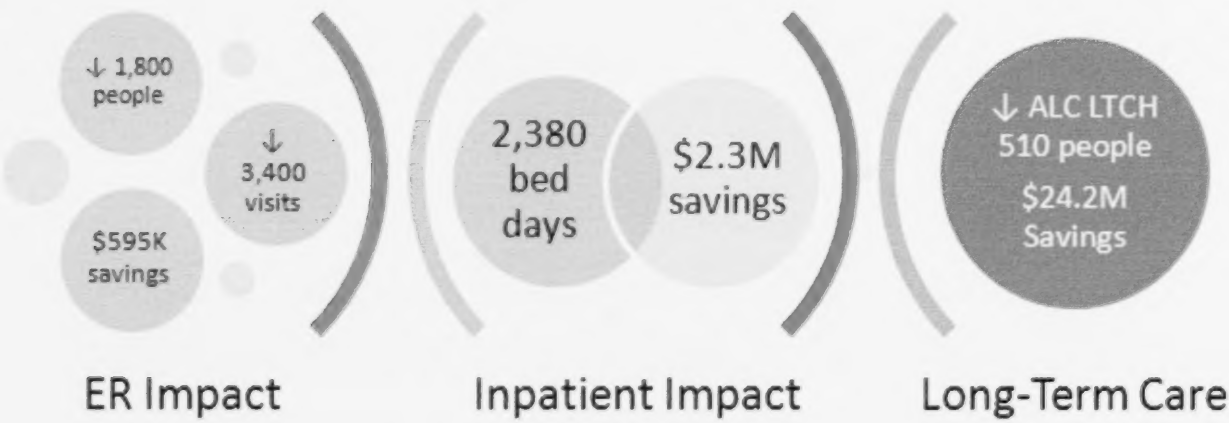
Business Process Redesign: where we considered operational improvements that will reduce miscommunication, delays in processing and errors than might lead to rework.

Management of Clients' Needs: by ensuring that waiting lists for appropriate care were established. Setting target times by which services had to be delivered ensured patients received care at the right time.

Identifying Physical Resources: where reviewing case presentations, along with the data, helped us identify the resources needed to avoid ED visits in the first place, and help patients go home as soon after their hospital stay as possible.

Inability to Manage Assisted Daily Living

Thanks to the SMILE (*Seniors Managing Independent Living Easily)* program, *Easier +*, and other collaborative efforts through the CCAC and CSS, a web of care has been created for seniors to help them manage their ADL. These services are provided in an effort to avoid repeat ED visits and are meant to hasten their discharge from hospital.



Impact of the SE LHIN SMILE Program

Trigger Events

The early identification of frail-elderly patients by ED staff who observe their arrival and progress can lead to a referral and an assessment for the kind of community home support services those patients may need. This review of early ALC designation also helps in identifying additional process improvements that may be required within the LTCH sector to reduce repeat ER visits and have patients discharged from hospital as early as possible.

Emergency Department Visits – Capacity & Performance

Understanding the patient flow within a hospital Emergency Department has helped the SE LHIN understand, and improve upon, our ED Wait Times.

The two largest Emergency Departments in our region received *Pay for Results* (P4R) funding in 2010/11. Although they have the longest ER wait times, we know they worked hard to reduce them. Kingston General Hospital, for example, had achieved patient flow improvements among their non-admitted patients and reductions in the time it takes to see a physician. Wait times for admitted patients (those patients who visit an ED and require hospitalization) however, are still above provincial targets.

2010/11 was the first year in which Quinte Health Care – Belleville, received P4R funding. They had put considerable effort into learning and adopting process improvements, and reducing patient flow barriers both within the ED and the inpatient unit. Initial findings noted that bed turnaround times (the time between when a discharged patient leaves a bed until the next time it's occupied) had also improved.

Hospital Admissions

Through an integrated discharge planning process, patients at high risk for needing ALC are being identified earlier to avoid the physical and cognitive decline that can accompany a lengthy hospital stay. This process also helps avoid inappropriate ALC designation or delays in discharge. Programs included in this planning process are *Home First* and *Enhanced Activation Therapy.*

Acute Care ends – patient goes home

An important cultural paradigm shift has taken place throughout the SE LHIN – one that attempts to ensure every patient gets the opportunity to go home first, before any alternate care setting is discussed.

ER/ALC Initiatives to reduce ED visits

SMILE Program

SMILE *(Seniors Managing Independent Living Easily)* is a program unique to the SE LHIN. It enables seniors to live independently in their own homes by providing them with support services for household tasks they may not be able to perform for themselves, such as mowing a lawn or shopping for groceries. The SMILE Program coordinating agency provides these types of services that may be needed above and beyond those already provided by CCAC and CSS agencies. If there is no local provider available, SMILE will pay for these services to be provided by whoever the client

wishes to employ. Since SMILE was launched over three years ago, the number of patients waiting for long-term care has dropped by 700.

ED Capacity and Performance

The LHIN's strategy to improve upon wait times is a combination of reducing reliance on EDs, as well as improving upon how well EDs operate. Seeing and treating patients through alternative ED processes has significantly reduced the time patients have to wait to receive care. Patients waiting for admission to hospital from the Emergency Department, however, still have long waits before an inpatient bed is made available for them. This is a province-wide issue.

Alternate Level of Care – Improving access to post-hospital care options

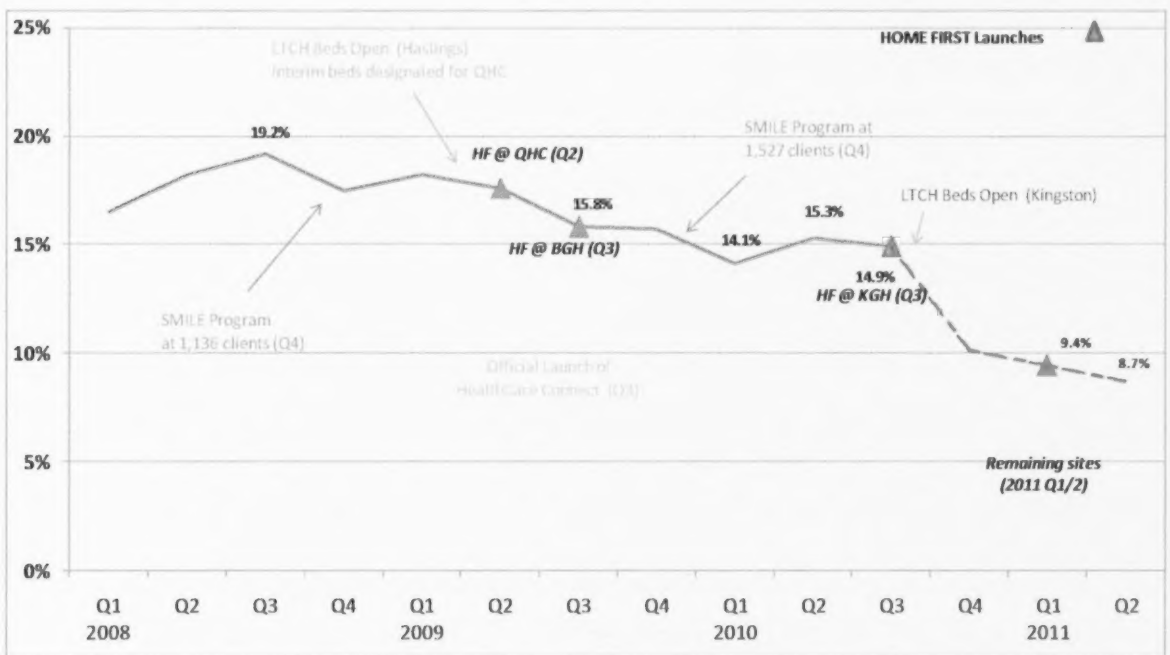
By working together, Health Service Providers have improved the flow of patients out of hospital by reducing the number of people waiting for long-term care placement or alternate level of care destinations; reducing the median wait time for that placement; and implementing programs that enable people to wait at home until a permanent care destination becomes available.

There continues to be a lower percentage of hospital beds occupied by ALC patients, which, in turn, should lead to a reduction in ER wait times. That said, there also appear to be instances where reduced ALC has *not* reduced ER wait times.

Further business-process improvements are required if we are to achieve the ideal balance of matching each admitted patient with one who is discharged.

Home First

The *Home First* philosophy enables frail seniors to return home following an acute-care hospital stay rather than being sent to an alternate level of care. It speaks to the cultural paradigm shift mentioned above that sees many patients going home after



their hospital care, whereas in the past they would have had to wait in hospital for a long-term care home bed to become available.

First launched at QHC in 2009/10, *Home First* has since been adopted at Brockville General Hospital and Kingston General Hospital. This has led to a gradual reduction over this past year in the number of patients being designated as requiring ALC. By improving hospital-to-community discharge processes and access to community services, the *Home First* philosophy has seen a reduction in unnecessary hospitalization.

Furthermore, over half of those seniors who went home thanks to *Home First* are still in their homes. This has reduced the demand for long-term care home beds, which, in turn, will enable those who *do* need that level of care to get it sooner. The SE LHIN intends to continue expanding on this philosophy in 2011/12.

Discharge Link

Discharge Link was launched in February, 2009, to provide enhanced community-based rehabilitation services at home and in long-term care homes for stroke survivors. Services provided through this program include physiotherapy and access to occupational health and social workers. Initial evaluation has demonstrated a reduction in Length of Stay (LOS) and overall better patient outcomes.

The *Discharge Link* model of care has been adopted for high-risk frail seniors who require intense rehabilitation therapy while in hospital to help them avoid decline. It also coordinates community services to ensure patients – once they're discharged – continue to maintain or strengthen their physical and cognitive abilities. Early stages of this *Enhanced Activation* program have already helped achieve a reduction in ALC as patients or their families are feeling "healthier and more able to manage at home."

Home at Last

A simple solution for patients whose discharge from hospital may be delayed due to the temporary lack of appropriate support in their home environment is to provide them with transportation home and help to get them settled. This includes providing services such as grocery shopping, meal preparation or housekeeping services that are available through Community Support Services agencies.

Interestingly, over 57% of the clients who received these temporary *Home at Last* services went on (and continue) to pay independently for help with their day-to-day living at home.

Overall, the South East LHIN's integrated ER/ALC strategy is intended to meet or exceed Ontario's targets for wait times and access, while meeting local health care needs. We are already seeing highly-positive results within just a few months of the launch of these various projects and programs described above. We expect even greater results going forward.

7 Implementing the Ontario Diabetes Strategy

Due to the high prevalence and impact of diabetes in the South East, an essential first step into chronic disease management will be to focus on this serious disease. We have opportunities to integrate diabetes care and the monitoring of management indicators. Lessons learned will drive other chronic disease management strategies.

Activities supporting this priority

Alignment with the Ontario Diabetes Strategy: Diabetes is a serious chronic disease that is costly to the individual, their families, and society alike. Patients living with diabetes are encouraged to self-manage their disease by making healthy lifestyle choices and by taking medication if needed.

Because of its complex nature, effective management of the disease and the avoidance of serious complications requires access to a range of health-care services. The SE LHIN is supporting the Ontario government by developing a comprehensive diabetes strategy that will prevent, manage and treat the disease. Patients with diabetes within the SE LHIN will benefit from improved health promotion, information on prevention, increased access to diabetes care and more coordinated services to help them manage the disease.

South East Diabetes Regional Coordination Centre (DRCC): A new organization that will help to coordinate and improve diabetes services, the DRCC was launched in the South East in 2010, attached to the Community Health Centre in Merrickville. As one of 14 such centres across Ontario, and as part of the Ontario Diabetes Strategy, the goal of the SE LHIN CCR is to help better organize and manage local diabetes programs and to improve the health and health outcomes for patients living with, or at high risk of developing, diabetes.

Diabetes Self-Management Initiative: Hosted by the Kingston CHC, the aim of the Ontario Diabetes Strategy Self-Management Initiative is to provide support tools and expertise to foster self-management capability. This includes capacity-building for service providers, communities and individual diabetics through: training and coaching/mentoring of multidisciplinary service providers to integrate self-management approaches into their practice; and training of Peer Leaders and Master Trainers to increase access to, and delivery of, Chronic Disease Self-Management Skill Building Group Programs for individuals with diabetes.

8 Furthering Access Through E-Health

E-health is a key enabler to achieving an integrated system of care. E-health will ultimately produce an electronic health record, but will also advance the electronic transfer of diagnostic requests and results, standard referral protocols, timely communication between professionals, and rapid access to current research. The South East LHIN will advance its e-health strategy in coordination with the provincial e-health strategy. E-health will lead and enable the diabetes strategy roll out. E-health will also lead and enable the regional surgical program e-referral initiative. Further, e-health will lead and enable initiatives to develop primary health care as a regional system of care.

Activities supporting this priority

InterRAI CHA Common Assessment Tool: The InterRAI CHA has been fully implemented. Thirty-two agencies have been introduced to the assessment tool and 100 per cent of the identified full-assessor agencies are currently using the software and have successfully integrated the tool into their business processes. Frequent comments about the tool speak to how easy it is to use, its sustainability for small and large agencies alike, and its ability to identify and flag areas of concern.

Regional Surgical eReferral: A pilot project was implemented to improve the quality of the referral process related to orthopedic surgery for hips and knees. This project has built a foundation of technology and clinical processes that can be built upon to expand eReferral benefits to other primary care-specialist pathways.

Health Service Provider eHealth Solution Adoption: The SE LHIN's ***Implementation and Adoption*** initiative developed capacity in key foundational areas, including the support of Project Management, Service Management, Governance, Regional Active Directory, Regional Applications, Regional Strategic Planning and Stakeholder Engagement activities across this region.

Resource Matching and Referral: The SE LHIN took up representation on the provincial RM&R steering committee, thereby engaging more directly with the early stages of rolling out this initiative.

9 Expanding Culturally and Linguistically Sensitive Health-care Services

The South East LHIN is committed to working with French language communities, and the health providers serving them, to ensure there is appropriate access to care in the French language. Equally, the South East LHIN will work with its Aboriginal communities to offer assistance in their efforts to ensure appropriate access to care.

Activities supporting this priority

Appointment of a French Language Services Coordinator: In June, 2010 the SE LHIN hired a full time permanent FLS Coordinator to help with the integration of French Language Services into the health care system across the south east. Armed with the mandate to increase the availability of services in French, our FLS Coordinator has been active in mapping out a regional strategy to develop an overall improvement in access to those services in accordance with the French Language Services Act (FLSA).

Her appointment was followed shortly thereafter with the appointment last July of Ottawa-based *Le Reseau des Services de Sante en Francais de l'Est de l'Ontario* as the French Health Planning Entity for the SE LHIN.

Over this past year the FLS Coordinator has embarked upon a series of outreach activities to build a network of contacts with whom she will work closely over the near to long term, including her presence at the AGM of ACFO (*Association Canadienne Francaise de l'Ontario*) in Kingston in June; her attendance at the AGM of *le Reseau* in Ottawa in September; and her participation in the advisory committee of *"Ma Sante c'est ma vie"* project regarding the health needs of francophone youth.

In December she became a member of the "Designation Committee" at the Reseau – participating in monthly meetings designed to support health organizations in improving the level of services they deliver in French so they can obtain their designation under the FLS Act. She also facilitates periodic meetings with FLS-designated HSPs in Kingston to support them in the implementation of their FLS plans.

Engagement with Aboriginal Populations: In its determination to forge stronger working relationships with Aboriginal populations, the SE LHIN Board Chair, CEO and staff held quarterly meetings with the Chief and Council of the **Mohawks of the Bay of Quinte**. Additionally, the LHIN successfully negotiated funding for an Aboriginal Nurse Practitioner position for the Tyendinaga community through the Belleville-Quinte West CHC – and has provided ongoing support for the development of their strategic plan in the areas of mental health and diabetes.

In 2010 the SE LHIN worked with the **Metis Nation of Ontario** to develop (in a partnership between the MNO, the Central East LHIN and the SE LHIN) a

health population survey for all MNO residents of this region. While the survey itself will be undertaken in 2011/12, the preparatory groundwork leading to it was accomplished during this past fiscal year.

10 Advancing System Improvement Through Boards Working Together

The role of health-care governance is evolving in the LHIN environment, where boards are not just responsible for overseeing the management of their own organization, but also for contributing to the development and functioning of an integrated system of care. The South East LHIN will continue to nurture an environment where Boards are working together to lead and support integration and system development.

Activities supporting this priority

Collaborative Governance: Since its creation in late 2005, the SE LHIN has communicated, regularly and often, with its HSP partner Board Chairs and Members. These informal early meetings led to the SE LHIN Board appointing a formal Collaborative Governance Development Team (CGDT) in 2007.

The CGDT has representation from each service sector (mental health and addictions services, community care access centres, community health centres, community support services, hospitals, and the long-term care sector) as well as members from the academic health sciences, primary health care and public health sectors. The CGDT was established to provide advice to the SE LHIN Board and Chair on how to engage at the governance level and how to promote and encourage boards to work together to achieve greater alignment with the LHIN's objectives.

Since 2007, on the advice of the CGDT, our Board has held a series of governance working sessions each year. Hosted throughout our geographic area, these sessions have focused on areas which the CGDT felt would engage board members and contribute to the advancement of LHIN priorities.

Sessions have included workshops for new members of Health Service Provider Boards in Belleville, Perth, Brockville and Kingston.

In addition, our Board Chair leads a monthly meeting of the chairs of the LHIN's hospitals and CCAC. Overall, our Board is demonstrating that the engagement of HSP boards is a valuable enabler of integration and advancing our priorities. One very practical example of this is the inclusion of Board Chairs at several update sessions to inform them of progress related to our Regional Clinical Services Roadmap initiative.

The South East LHIN Knowledge Management Team

The Knowledge Management team is the intelligence, the eyes and the ears of the South East LHIN. It gathers, and provides thoughtful analysis of, key health indicators and trends upon which the LHIN can make solid, valid decisions regarding programs that merit additional support or gaps that must be closed.

The Knowledge Management team does this by developing and managing regional health and other related databases; assessing and reporting on key performance indicators; providing analytical leadership on a variety of projects; and collaborating with HSPs and other stakeholders. The main activities of the team during fiscal 2010-2011 include:

Database/System Development and Management: The Regional Health System Database Feasibility Project examined options for establishing a regional database of hospital and community health system data. The Hamilton Health Service and other local models were examined and governance and technical support structures discussed. Any future implementation would need to also consider the provincial *One Source System* that currently provides basic health service reporting but is expected to undergo significant expansion that will allow analysis of almost all regional hospital service data.

Information on Critical Care, Patient Safety, Addictions and Canadian Community Health Status data were added to the SE LHIN data repository.

Development and structuring of the South East LHIN *SharePoint* intranet site (which was launched in Q1 2011) happened during 2010/11. The Document Centre component of the system was implemented and the requirements for the site design initiated. Once fully-functional, *SharePoint* document storage will be more efficient and a number of collaboration tools will improve the flow of information among LHIN staff.

Project Support: Significant Knowledge Management team resources were devoted to supporting the momentum of the Clinical Services Roadmap initiative. In order to validate preliminary recommendations on which service areas required further development, *The Regional Analysis of SE LHIN Hospital Services* report was prepared. This highly-detailed and comprehensive report summarizes socioeconomic context and chronic disease trends, health service utilization patterns – including trends in critical care, patient safety and palliative care – and a summary of feedback from hospitals on proposed system developments. The final section of the report

confirmed the majority of selected clinical areas of opportunity that the CSR must tackle, and suggested additional service areas for future consideration.

Other project support activities focused on supporting Community Health Centres with the conducting of a study of primary health-care needs and services used by residents of the South East LHIN region. The results of this investigation will help identify specific segments of the population who may be receiving uneven or inequitable primary health-care services. The results will also inform and guide planning in those service areas.

The Knowledge Management team was also instrumental in helping the Metis Nation of Ontario to design a survey instrument that will evaluate the health status and needs of the Metis Population in eastern Ontario.

It also brought forward implementation of the *NesdaTrak* system in the South East LHIN Alzheimer's Agencies. This client-management system is used by the majority of regional community support service agencies to capture reliable and consistent utilization data that can be used for operations, planning and research activities.

South East LHIN Performance Indicators

Fiscal Year 2010/2011

PI #	Performance Indicator	Indicator Type	Provincial Target	LHIN Starting Point or Baseline	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11	LHIN FY2010/11 Target	Percent From Target for Most Recent Quarter*	FY 2010/11 LHIN Annual Result
1	90th Percentile Wait Times for Cancer Surgery	Access	84 days	51	45	54	48	56	51	13.7%	51
2	90th Percentile Wait Times for Cardiac By-Pass Procedures	Access	182 days	64	29	56	85	35	64	-45.3%	51
3	90th Percentile Wait Times for Cataract	Access	182 days	97	96	125	109	118	97	21.6%	112
4	90th Percentile Wait Times for Hip Replacement	Access	182 days	146	128	160	151	124	146	-15.1%	141
5	90th Percentile Wait Times for Knee Replacement	Access	182 days	148	145	157	153	131	148	11.5%	145
6	90th Percentile Wait Times for Diagnostic MRI Scan	Access	28 days	95	56	85	103	96	72	36.1%	94
7	90th Percentile Wait Times for Diagnostic CT Scan	Access	28 days	27	28	21	17	20	27	-25.9%	22
8	Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution***	Integration	9.5%	16.8%	14.5%	15.3%	15.0%	N/A	10.1%	48.4%	14.8%
9	90th Percentile ER Length of Stay for Admitted Patients	Access	8 hours	26.7	28.0	25.8	27.1	27.0	25.0	7.9%	26.8
10	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS IV-V) Patients	Access	8 hours	7.0	7.1	6.8	6.8	6.8	6.8	0.2%	6.9
11	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	Access	4 hours	4.2	3.9	4.1	4.1	4.0	4.0	0.8%	4.0
12	Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions**	Access	TBD	15.4%	14.2%	15.5%	N/A	N/A	13.1%	18.5%	14.9%
13	Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions**	Access	TBD	14.3%	25.1%	20.7%	N/A	N/A	14.3%	44.7%	22.7%
14	Readmission within 30 Days for Selected CMGs**	Efficiency	TBD	15.2%	15.0%	15.6%	N/A	N/A	14.3%	8.8%	15.6%

Notes: * A negative percentage means the LHIN has met its target

** FY 2010/2011 is based on only 2 quarters of data (Q1-Q2 2010/11) due to availability

*** FY 2010/2011 is based on only 3 quarters of data (Q1-Q2 2010/11) due to availability

The above table provides the available results of key performance indicators in the Ministry-LHIN Performance Agreement (MLPA) for the 2010/11 fiscal period. For the majority of priority surgical and DI procedures (including cancer, cardiac by-pass, hip and knee surgeries and CT scans) the LHIN has achieved the expected wait time targets not only at the provincial levels but also at the regional levels. Monitoring and sustaining these levels will remain as an important priority for the 2011/12 period.

LHIN Commentary on Performance Indicator Results

Other key performance indicators in the MLPA have tended to fluctuate around desired targets. Each of these indicators are presented below along with a review and steps to address gaps in performance.

Cataract Surgery Wait Time 90th Percentile Wait (days)	Target		LHIN Start	Quarterly Performance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	182	97	97	96	125	109	118	112

Cataract Wait Times – Starting with a LHIN baseline of 97 days, the 90th percentile wait time for completed cataract surgery procedures peaked during the summer season before reaching around 118 days at the end of the year. The LHIN has been holding quarterly meetings with hospitals to discuss performance and identify potential solutions including reallocating volumes between institutions. Examination of the Regional Surgical Program as part of the Clinical Service Roadmap project is another mechanism that will be employed to reduce cataract surgery wait times to expected levels.

MRI Scan Wait Time 90th Percentile Wait (days)	Target		LHIN Start	Quarterly Performance				Result
	Province	LHIN		Q1	Q2	Q3	Q4	
	28	72	95	56	85	103	98	94

MRI Wait Times – The 90th percentile wait time for completing an MRI scan was set to 72 days at the beginning of the fiscal period. Although the LHIN strived to maintain its Q1 wait time of 56 days, both hospitals providing this service experienced a number of challenges including unavailability of technicians to meet increasing demands and an increase in no-show appointments that resulted in lost capacity to the system. Both of the hospitals providing this service have signed onto the ministry-led Performance Improvement Project and have begun to identify mechanisms to reduce wait times for these scans

Mental Health Repeat Visits to ER Return within 30 days	Target		LHIN Start	Quarterly Performance				Result
	Province	LHIN	15.4%	Q1	Q2	Q3	Q4	14.9%
	TBD	13.1%		14.2	15.5	NA	NA	

Substance Abuse Repeat Visits to ER Return within 30 days	Target		LHIN Start	Quarterly Performance				Result
	Province	LHIN	14.3%	Q1	Q2	Q3	Q4	22.7%
	TBD	14.3%		25.1	20.7	NA	NA	

Repeat ER Visits for Mental Health Conditions – Repeat visits for both mental health conditions and substance abuse were introduced in the MLPA in fiscal 2010/11. Closer examination of the indicators has pointed to a small group of clients with relatively high recidivism to the ER and efforts through the CSR project will aim to work with community service providers to provide adequate service to these individuals.

Readmission for Selected Groups Readmission within 30 days	Target		LHIN Start	Quarterly Performance				Result
	Province	LHIN	15.2%	Q1	Q2	Q3	Q4	15.6%
	TBD	14.3%		15.0	15.6	NA	NA	

Readmission for Selected CMGs – Readmission for selected CMGs (case mix diagnostics and clinical groups) was introduced in fiscal 2010/11 with a LHIN target of 14.3%. Although with only 2 quarters of data showing relative stability in these readmissions, the LHIN has identified that congestive heart failure, COPD and gastrointestinal diseases have the highest readmissions and will be a focus of the CSR project.

Funding Allocation

Total: $6,482,270
Base: $4,782,270
Project: $1,700,000

South East LHIN management administered an allocation of $6,482,270 in fiscal year 2010/11. The allocation is comprised of the LHIN's total corporate operational budget of $4,782,270 along with special ancillary project-based funding totaling $1,700,000.

Ancillary Project-based Funding

The LHIN received special funding for projects supporting Ministry of Health and Long-Term Care health system priorities, and LHIN Integrated Health Services Plan Priorities for Change. These projects included:

- e-Health Project Management Office†
- e-Health Provincial Coordination
- e-Health Implementation and Adoption
- Emergency Room / Alternative Level of Care Strategy†
- Emergency Department Initiative
- Aboriginal Community Engagement Initiative
- French Language Services Initiative†
- Critical Care Initiative

† A Ministry of Health and Long-Term Care condition of funding is the selection of an individual to lead this project. Project leads are provided with work space within the LHIN offices.

SE LHIN Office Move

Of special note, after five years of inhabiting an inadequate space, the SE LHIN moved offices to a new location in Belleville in February. While the move was fully supported by a strong business case, and while it was made in order to achieve greater operational efficiencies, it does represent an extra-ordinary expense to the FY 2010/11 budget.

2010/2011 Audited Financial Statements

An external audit was conducted by Deloitte & Touche LLP in April 2011. A copy of the auditor's report is provided in the following section of this document. The results of the audit for the 2010/2011 fiscal year were very positive. The South East LHIN ended the fiscal year in a balanced financial position.

Statutory Compliance – Ontarians with Disabilities Act, 2001

Pursuant to direction from the Accessibility Directorate of Ontario, the South East LHIN has met its obligations under statute and has ensured that Ontarians with disabilities have access to our facilities, services, and information made available to the public.

Financial statements of

South East Local Health Integration Network

March 31, 2011

South East Local Health Integration Network

March 31, 2011

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Independent Auditor's Report

To the Members of the Board of Directors of the
South East Local Health Integration Network

We have audited the accompanying financial statements of the South East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2011, and the statements of financial activities, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31, 2011, and the results of its financial activities, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 30, 2011

South East Local Health Integration Network

Statement of financial position
as at March 31, 2011

	2011	2010
	$	$
Financial assets		
Cash	**1,373,084**	975,076
Accounts receivable	**65,589**	-
Due from the LHIN Shared Services Office (Note 5)	**-**	1,895
	1,438,673	976,971
Liabilities		
Accounts payable and accrued liabilities	**815,436**	854,148
Due to MOHLTC (Note 3)	**302,497**	128,747
Due to the LHIN Shared Services Office (Note 5)	**19,552**	-
Deferred capital contributions (Note 6)	**621,198**	289,421
Obligations under capital lease (Note 14)	**315,807**	-
	2,074,490	1,272,316
Net debt	**(635,817)**	(295,345)
Non-financial assets		
Prepaid expenses	**14,619**	5,924
Capital assets (Note 7)	**621,198**	289,421
	635,817	295,345
Accumulated surplus	**-**	-

Approved by the Board:

Georgina Thompson
Board Chair

Ian Fraser
Audit Committee Chair

South East Local Health Integration Network

Statement of financial activities
year ended March 31, 2011

	Budget (Unaudited) (Note 8)	2011 Actual	2010 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**942,397,736**	**1,017,913,350**	960,628,457
Operations of LHIN (Notes 3, 8 and 10)	**4,711,570**	**4,302,588**	4,667,028
e-Health (Note 4a)	**1,325,000**	**1,325,000**	600,000
Emergency Department (Note 4b)	**75,000**	**75,000**	75,000
Aboriginal Initiative (Note 4c)	**15,000**	**15,000**	15,000
ER/ALC Initiative (Note 4d)	**100,000**	**100,000**	100,000
French Language Services Initiative (Note 4e)	**110,000**	**110,000**	-
Critical Care Initiative (Note 4f)	**75,000**	**75,000**	-
Aboriginal Health Transitions Fund Initiative	-	-	20,000
Ontario Diabetes Strategy	-	-	25,000
Amortization of deferred capital contributions (Note 6)	-	**147,905**	47,665
	948,809,306	**1,024,063,843**	966,178,150
Expenses			
Transfer payments to HSPs (Note 9)	**942,397,736**	**1,017,913,350**	960,628,457
General and administrative (Note 10)	**4,711,570**	**4,447,604**	4,657,862
e-Health (Note 4a)	**1,325,000**	**1,039,120**	567,499
Emergency Department (Note 4b)	**75,000**	**73,937**	57,227
Aboriginal Initiative (Note 4c)	**15,000**	**15,000**	15,000
ER/ALC Initiative (Note 4d)	**100,000**	**100,000**	100,000
French Language Services Initiative (Note 4e)	**110,000**	**99,310**	-
Critical Care Initiative (Note 4f)	**75,000**	**73,025**	-
Aboriginal Health Transitions Fund Initiative	-	-	20,000
Ontario Diabetes Strategy	-	-	9,253
	948,809,306	**1,023,761,346**	966,055,298
Annual surplus before funding repayable to the MOHLTC	-	**302,497**	122,852
Funding repayable to the MOHLTC (Note 3A)	-	**(302,497)**	(122,852)
Annual surplus and closing accumulated surplus	-	-	-

South East Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2011

	2011	2010
	$	$
Annual surplus	-	-
Acquisition of capital assets	**(479,682)**	(44,541)
Amortization of capital assets	**147,905**	47,665
(Increase) decrease in prepaid expenses	**(8,695)**	20,244
(Increase) decrease in net debt	**(340,472)**	23,368
Opening net debt	**(295,345)**	(318,713)
Closing net debt	**(635,817)**	(295,345)

South East Local Health Integration Network

Statement of cash flows
year ended March 31, 2011

	2011	2010
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**147,905**	47,665
Amortization of deferred capital contribution (Note 6)	**(147,905)**	(47,665)
Changes in non-cash operating items		
(Increase) decrease in accounts receivable	**(65,589)**	1,788
Decrease in due from LHIN Shared Services Office	**1,895**	-
(Increase) decrease in prepaid expenses	**(8,695)**	20,244
Decrease in accounts payable and accrued liabilities	**(38,712)**	(162,834)
Increase in due to MOHLTC	**173,750**	122,852
Increase (decrease) in due to the LHIN Shared Services Office	**19,552**	(18,592)
	82,201	(36,542)
Capital transaction		
Acquisition of capital assets	**(479,682)**	(44,541)
Financing transactions		
Increase in deferred capital contributions (Note 6)	**479,682**	44,541
Increase in obligations under capital lease	**319,178**	-
Repayment of obligations under capital lease	**(3,371)**	-
	795,489	44,541
Net increase (decrease) in cash	**398,008**	(36,542)
Cash, beginning of year	**975,076**	1,011,618
Cash, end of year	**1,373,084**	975,076

1. Description of business

The South East Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the South East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long-Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2011.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN is home to over 489,600 people, which encompasses the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the towns of Smith Falls and Prescott, and part of Lanark and Northumberland Counties. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and losses in the book value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at year end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Maintenance and repair costs are recognized as an expense when incurred. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized, on a straight line basis, over their estimated useful lives as follows:

Office Equipment	5 years
Computer Equipment	3 years
Infrastructure/Web Developments	3 years
Leasehold Improvements	Life of lease

For assets acquired and brought into use, during the year, amortization is provided for a full year.

2. Significant accounting policies (continued)

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of financial activities and within the related notes for both the prior and current year sufficiently disclosed information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the accounting policy related to deferred capital contributions (Note 2) the LHIN has recognized the amortization of deferred capital contributions of $147,905 (2010 - $47,665) as revenue. LHIN Operations base funding for 2011 after adjustments was $4,782,270 as detailed in Note 8.

A. The amount repayable to the MOHLTC is made up of the following components:

			2011
	Revenue	Expenses	Surplus
	$	$	$
Transfer payments to HSPs	1,017,913,350	1,017,913,350	-
LHIN operations	4,450,493	4,447,604	2,889
E-Health	1,325,000	1,039,120	285,880
Emergency department initiative	75,000	73,937	1,063
Aboriginal initiative	15,000	15,000	-
ER/ALC Initiative	100,000	100,000	-
French Language Services Initiative	110,000	99,310	10,690
Critical Care Initiative	75,000	73,025	1,975
	1,024,063,843	1,023,761,346	302,497

B. The amount due to the MOHLTC at March 31 is made up as follows:

	2011	2010
	$	$
Due to MOHLTC, beginning of year	128,747	5,895
Funding repaid during the year	(128,747)	-
One-time funding repayable to the MOHLTC	299,608	66,021
LHIN Operations funding repayable to MOHLTC	2,889	56,831
Due to MOHLTC, end of year	302,497	128,747

4. a) e-Health Initiative

i) Project Management Office (PMO)

During fiscal 2011, the South East LHIN received funding in the amount of $600,000 from the MOHLTC. These funds were used toward initiatives in support of its strategic e-Health Plan as defined in its Integrated Health Services Plan. Unspent funds, amounting to $10,072 at year end, are repayable to the MOHLTC.

	$
Expenses	
Salaries and benefits	412,759
Consulting services	77,863
Travel	18,426
Meeting expenses	5,468
Accommodations	17,077
Shared services	31,956
Other	26,379
	589,928

ii) Implementation and adoption

During fiscal 2011, the South East LHIN received funding in the amount of $450,000 from the MOHLTC. These funds were used for the Implementation and Adoption Getting Ready Initiative in alignment with the Provincial eHealth Strategic Plan. Unspent funds, amounting to $133,252 at year end, are repayable to the MOHLTC.

	$
Expenses	
Consulting services	310,446
Travel	3,585
Meeting expenses	2,717
	316,748

iii) Provincial Coordinator

During fiscal 2011, the South East LHIN received funding in the amount of $275,000 from the MOHLTC. These funds were used to support the Provincial Coordination role, and related eHealth activities on behalf of all 14 LHINs, these activities were in alignment with the Provincial eHealth Strategic Plan. Unspent funds, amounting to $142,556 at year end, are repayable to the MOHLTC.

	$
Expenses	
Salaries and benefits	75,563
Travel	656
Meeting expenses	3,121
Other	53,104
	132,444

4. (continued)

b) Emergency Department Initiative

During fiscal 2011, the South East LHIN received funding in the amount of $75,000 from the MOHLTC. These funds were used toward initiatives in support of the strategic Emergency Department Initiative and fell under the Access to Specialized Medical Services, within the Integrated Health Services Plan "Priority for Change". Unspent funds, amounting to $1,063 at year end, are repayable to the MOHLTC.

	$
Expenses	
Salaries and benefits	67,500
Travel	2,155
Other	4,282
	73,937

c) Aboriginal Initiative

During fiscal 2011, the South East LHIN received funding in the amount of $15,000 from the MOHLTC. These funds were used toward planning and engagement with the Aboriginal community in support of the Integrated Health Services Plan "Priority for Change".

	$
Expenses	
Other	15,000
	15,000

d) ER/ALC Initiative

During fiscal 2011, the South East LHIN received funding in the amount of $100,000 from the MOHLTC. These funds were used in support of the ER/ALC Strategy.

	$
Expenses	
Salaries and benefits	100,000
	100,000

Actual expenditures incurred as part of the ER/ALC Initiative activities were in excess of the $100,000 funding provided by the MOHLTC. The total of actual expenses is $136,754. The overage has been funded through LHIN Operations base.

	$
Expenses	
Salaries and benefits	126,593
Travel	7,068
Meeting expenses	433
Other	2,660
	136,754

4. (continued)

e) French Language Services Initiative

During fiscal 2011, the South East LHIN received funding in the amount of $110,000 from the MOHLTC. These funds were used in support of the French Language Services Strategy. Unspent funds, amounting to $10,690 at year end, are repayable to the MOHLTC.

	$
Expenses	
Salaries and benefits	62,345
Consulting services	11,535
Travel	4,377
Accommodations	4,269
Shared services	7,989
Other	8,795
	99,310

f) Critical Care Initiative

During fiscal 2011, the South East LHIN received funding in the amount of $75,000 from the MOHLTC. These funds were used in support of the ER/ALC Strategy. Unspent funds, amounting to $1,975 at year end, are repayable to the MOHLTC.

	$
Expenses	
Salaries and benefits	72,000
Travel	1,025
	73,025

5. Related party transactions

LHIN Shared Services Office (LSSO)

The LSSO is a division of the Toronto Central LHIN and, as such, is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end is recorded as a receivable from (payable to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

5. Related party transactions (continued)

LHIN Collaborative (LHINC)

LHINC was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in:

- fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system;
- their role as system manager;
- where appropriate, the consistent implementation of provincial strategy and initiatives;
- the identification and dissemination of best practices.
- LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the Ministry of Health and Long-Term Care.

LHINC is a division of Toronto Central LHIN and as such is subject to the same policies, guidelines and directives as the Toronto Central LHIN.

6. Deferred capital contributions

	2011	2010
	$	$
Balance, beginning of year	**289,421**	292,545
Capital contributions received during the year	**479,682**	44,541
Amortization for the year	**(147,905)**	(47,665)
Balance, end of year	**621,198**	289,421

7. Capital assets

			2011	2010
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office equipment	**408,007**	**128,943**	**279,064**	259,670
Computer equipment	**97,027**	**77,271**	**19,756**	6,380
Leasehold improvements	**475,051**	**152,673**	**322,378**	23,371
Infrastructure/Web development	**21,500**	**21,500**	-	-
	1,001,585	**380,387**	**621,198**	289,421

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2010. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirement. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

8. Budget figures (continued)

The total HSP funding budget of $1,017,913,350 is made up of the following:

	$
Initial HSP funding budget	**942,397,736**
Adjustment due to announcements made during the year	**75,515,614**
Total HSP funding budget	**1,017,913,350**

The total operating budget of $4,782,270 is made up of the following:

	$
Initial budget	**4,711,570**
Additional funding received during the year	**70,700**
Total budget	**4,782,270**

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,017,913,350 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2011	2010
	$	$
Operation of Hospitals	**676,287,800**	640,350,426
Grants to compensate for Municipal Taxation - Public Hospitals	**190,725**	190,725
Long-Term Care Homes	**157,270,059**	148,948,420
Community Care Access Centres	**96,933,755**	92,924,681
Community Support Services	**27,468,705**	23,443,792
Assisted Living Services in Supportive Housing	**2,003,991**	1,988,446
Community Health Centres	**18,371,448**	14,921,422
Community Mental Health Addictions Program	**39,386,867**	37,860,545
	1,017,913,350	960,628,457

10. General and administrative expenses

A. The Statement of financial activities presents expenses by function. The following classifies general and administrative expenses by object, as follows:

	2011	2010
	$	$
Program based		
Salaries and benefits	3,220,198	3,214,628
Consulting and LHIN-based projects	66,270	94,381
	3,286,468	3,309,009
Shared services	317,153	362,714
Collaborative	50,000	12,286
Other (details listed below)	198,604	343,509
Occupancy	118,505	152,006
Office equipment and supplies	106,674	143,261
Board per diem	132,270	165,752
Public relations	40,756	69,180
Mail, courier and telecommunications	49,269	52,480
	4,299,699	4,610,197
Amortization	147,905	47,665
	4,447,604	4,657,862

B. The breakdown of "Other" general and administrative expenses listed in the table above are:

	2011	2010
	$	$
Training and development	45,876	94,498
Travel	124,462	159,673
Recruitment	2,089	16,662
Insurance	17,640	16,319
Other miscellaneous	8,537	56,357
	198,604	343,509

C. The total expenses related to governance is as follows, and are included in the expenses listed in Note 10A above:

	2011	2010
	$	$
Board chair per diems	86,025	89,250
All other per diems	46,245	76,502
Total per diems	132,270	165,752
Other administrative costs	98,885	115,464
Total governance expenditures	231,155	281,216
Overhead - Salaries, benefits, accomodations and shared services	151,253	75,690
Total governance related costs	382,408	356,906

10. General and administrative expenses (continued)

D. The total occupancy and shared service costs are reduced in Note 10a above, due to partial cost sharing with ancillary funded projects for project staff who utilize office space and or shared services during the year. Reference Note 4 related to additional accommodations and shared services cost allocation.

11. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 22 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2011 was $261,295 (2010 - $250,426) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2010. At that time, the plan was fully funded.

12. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Minimum lease payments due next year under the building lease as follows:

	$
2012	224,064
2013	224,064
2014	224,064
2015	224,064
2016	224,064
Thereafter	1,101,648
	2,221,968

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2011 the LHIN has signed Accountability Agreements with all Hospitals for one more year, Community Agencies for the next three years, and Long Term Care Homes for the next two years. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

14. Obligations under capital lease

The LHIN has a leasehold agreement with the Landlord in which the Landlord recovers from the LHIN, the retrofit construction costs that are in excess of the regular lease costs over the term of the lease. Future minimum lease payments are as follows:

	$
2012	40,456
2013	40,456
2014	40,456
2015	40,456
2016	40,456
Thereafter	198,909
Future minimum lease payments	401,189
Less amount representing interest	(85,382)
Present value of future minimum rentals	315,807

Ontario
Local Health Integration Network